GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Public Hearing on

Fiscal Year 2020-21 Performance Oversight of the Department of Health Care Finance

Testimony of
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and
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Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent Gray, Chairperson

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WebEx Virtual Platform
The John A. Wilson Building
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Introduction

Good morning, Chairperson Gray and members of the Committee on Health. My name is Wayne Turnage and I serve as the Deputy Mayor for Health and Human Services and the Director of the Department of Health Care Finance (DHCF). I continue to serve in this dual role with the very capable support of my executive management team at DHCF, and the outstanding work delivered by the staff in the Office of the Deputy Mayor for Health and Human Services. In both agencies, we continue to work closely with the Office of the City Administrator and the Executive Office of the Mayor (EOM), advancing the policies and programs that promote equitable access to quality health care across all neighborhoods of the District of Columbia.

Thank you for the opportunity to discuss the activities and accomplishments of DHCF in Fiscal Year 2020 (FY2020) and Fiscal Year 2021 (FY2021), to date, on behalf of Mayor Muriel Bowser. As you know, for much of this period, DHCF has been forced to carry out its mission in an environment that has been severely complicated by the worst nationwide pandemic that this country has witnessed in 100 years. This public health crisis has forced District agencies to significantly modify operations to meet the needs of our residents who have largely been forced indoors by the threat of COVID–19. DHCF is no exception.

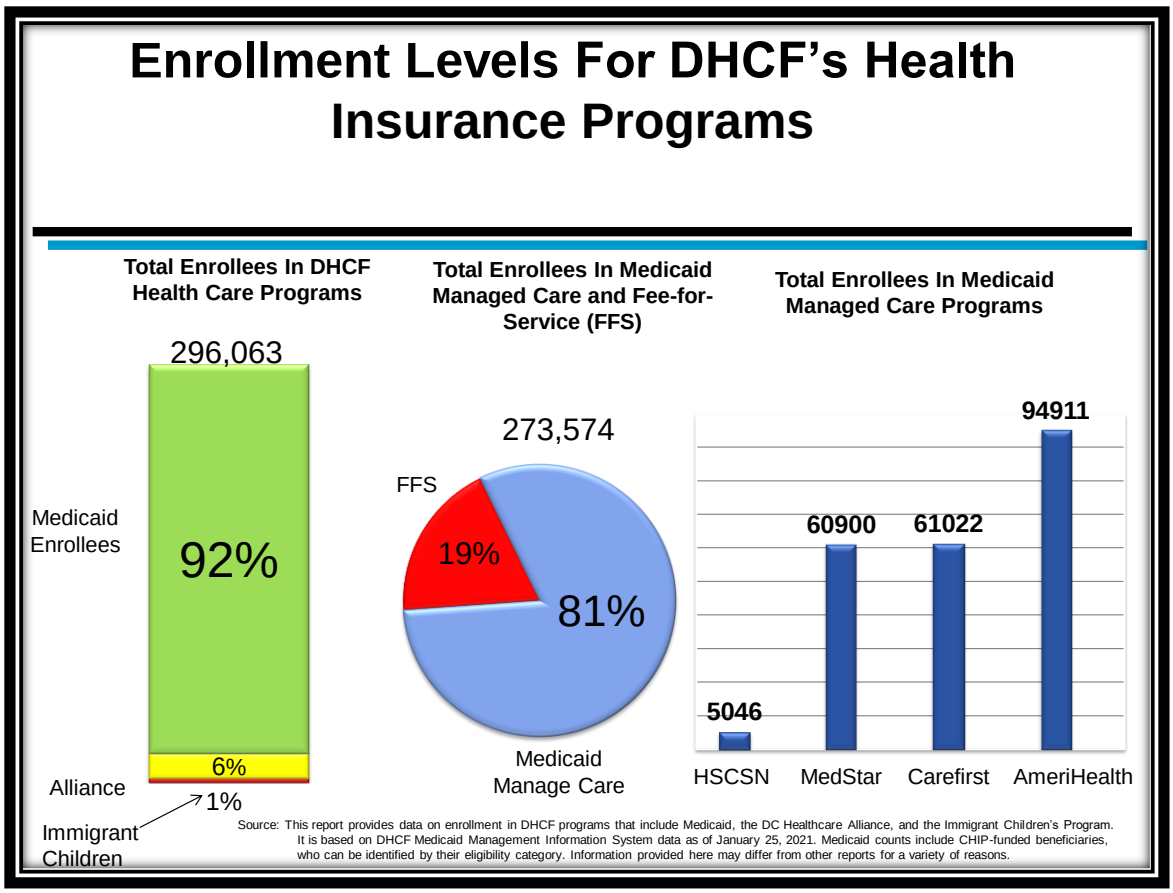
Accordingly, I will first highlight the many changes we established to ensure that enrollees in the Medicaid and Alliance programs retained access to the health benefits that are so desperately needed in this period of crisis. Following this discussion, I will outline the major priorities and program accomplishments that DHCF pursued in FY20 to further advance the broader goals we have for the Medicaid and Alliance programs. Finally, I will close my testimony with a discussion of our next steps as we continue moving forward with major Medicaid reform.

Agency Mission and Challenges

The mission of DHCF has remained unchanged since its formation in October 2008. The agency works to improve health outcomes by funding access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia. We do this through the administration of two primary insurance programs—Medicaid and Alliance, in addition to the Children's Health Insurance Program (CHIP) and the Immigrant Children's Program.

The enrollment levels for DHCF's health insurance programs are summarized in the graph on the next page. As shown, there are more than 296,000 District residents enrolled in the four health care programs administered by DHCF. The majority (92 percent) of these enrollees receive their health care services through the Medicaid program, which includes CHIP. The Alliance program, which is 100 percent locally funded, pays for the care of six percent of all program enrollees, with immigrant children comprising one percent of the beneficiaries in DHCF's publicly funded programs.

Due to changes to the Medicaid managed care program, roughly 8 of every 10 persons who are enrolled in the program receive their benefits through contracts that DHCF has established with four health care plans. Typically comprising from 72 to 76 percent of Medicaid enrollees, the current level represents an increase from previous years because of the Medicaid managed care expansion policies established by DHCF in FY2020. During this year, more than 16,000 enrollees who receive Supplemental Security Income (SSI) due to a disability, were transitioned from Medicaid fee-for-service (FFS) to managed care in the first phase of a what will be a broader expansion.



Responding To The Pandemic

Mr. Chairman, the next part of my testimony today offers details on how DHCF adjusted its operations to accommodate the needs of both enrollees and providers from the rapid and sharply expanding COVID–19 threat in the city. We pursued two principal goals in an effort to meet the needs of the community during the early phases of the pandemic:

1. Ensure ongoing access to care for beneficiaries in the event of an emergency, and

2. Expand program flexibility to allow persons to receive care in a setting that is most convenient given the challenges imposed by the pandemic.

Ensuring Access to Health Care. It was widely anticipated that one certain effect of the pandemic would be a suppression of commerce that would, in turn, trigger large-scale work force retrenchment, spiking both unemployment, a loss of health care coverage, and a demand for

publicly-funded health care insurance. In the District, between March and December 2020, residents filed more than 165,000 claims for unemployment insurance. This was a reliable indicator that more people than customary would eventually seek health care from the Medicaid and Alliance programs. In recognition of this prospect, the federal CARES Act increased the District's Medicaid federal match by 6.2 percent and required that no changes be made to eligibility policies that would reduce access to care.

Recognizing the challenge of access, DHCF responded by easing some of its eligibility requirements. For Medicaid, most notably, we automatically extended eligibility and, most significantly, waived requirements that enrollees report any changes in their status which could impact program eligibility. Also, DHCF permitted applicants to attest that they continue to meet program requirements without having to provide the typical documentation that is used to verify eligibility. For the Alliance program, we removed the much-discussed face-to-face application requirement for new enrollees and the six-month, face-to-face recertification requirement, as eligibility is automatically extended when recertification is required.

DHCF also utilized federal disaster authorities to make changes to provider reimbursement to allow providers to continue billing and be reimbursed at enhanced rates. Most notably, DHCF established a per-member, per-month rate for federally qualified health centers, providing stability during this turbulent time. Other changes included increasing rates to account for additional costs related to the public health emergency and establishing retainer payments to day providers.

These changes are summarized in Table 1 and they remain in effect until the end of the federally declared public health emergency. Originally due to expire in April of 2020, the Biden Administration announced in January 2021 that the federal Public Health Emergency (PHE) will likely extend through December 2021. Since, by rule, the PHE extends to the end of the quarter in

Table 1			
Type Enrollees	Medicaid	Alliance	Immigrant Children
Current Beneficiaries	• Eligibility automatically extended • Requirement to report changes is waived	• Eligibility automatically extended • Requirement to report changes is waived • No face-to-face interview	• Eligibility automatically extended • Requirement to report changes is waived
New Enrollees	• Allowing self-attestation of verification requirements except: ❖ U.S. citizenship and eligible immigration status ❖ Level of care requirements for long term care and Katie Beckett/TEFFR	• Face-to-face interview is waived • Allowing self-attestation of verification requirements except U.S. citizenship and eligible immigration status	• Allowing self-attestation of verification requirements except U.S. citizenship and eligible immigration status

which the expiration is identified, the District will reap the benefits of another 6.25 percent increase in its federal Medicaid match until December 2021. This allows DHCF to continue with relaxed eligibility policies through the end of this calendar year.

Table 2 indicates the changes that were made to the payment rates for six different provider groups, personal care aides, and nurses. These payments were instrumental in blunting losses for providers, allowing them to remain in business during a period of dramatic swings in program enrollments.

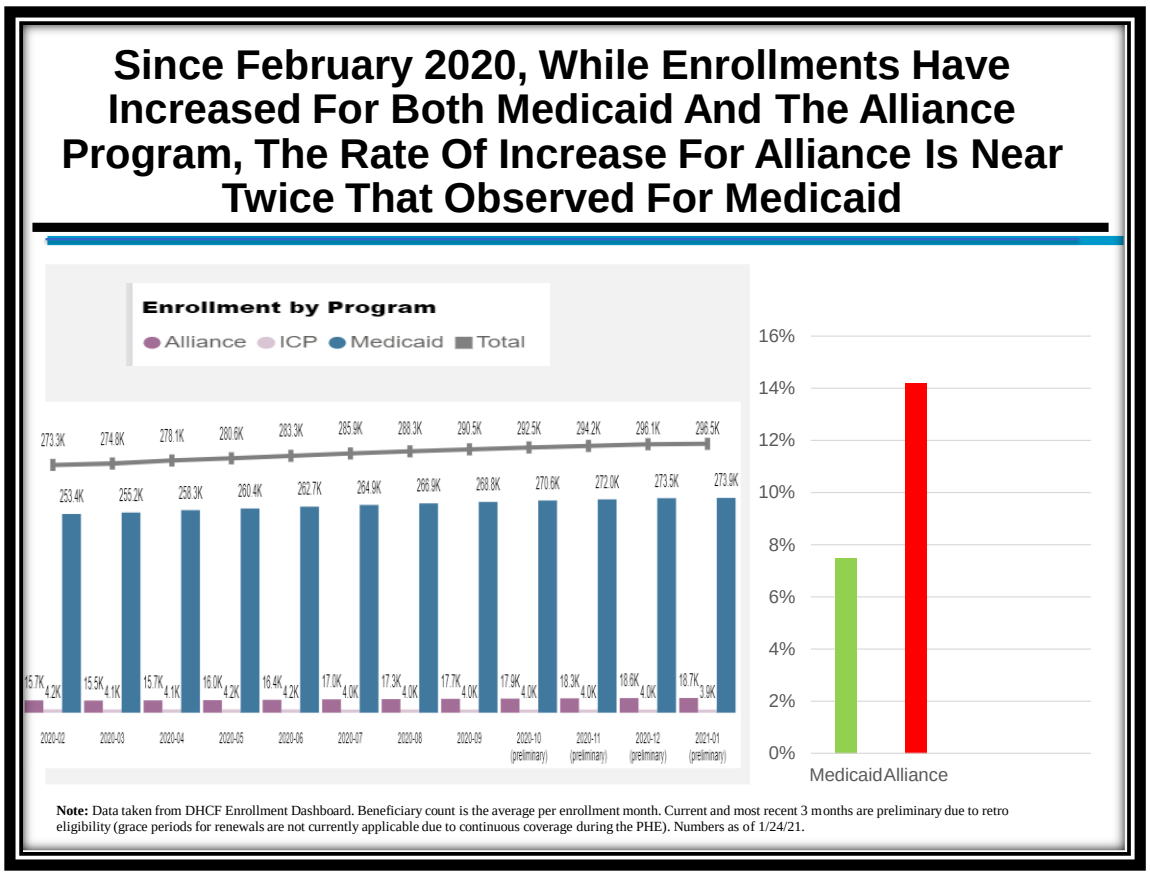
Table 2

Provider Reimbursement Increases During PHE

Provider Type	Rate Enhancement
Nursing Homes	20% increase to facility case-mix neutral base rate
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID)	15% increase to direct service personnel and active treatment component costs
Assisted Living Facility (ALF)	15% increase to reimbursement rate
Adult Substance Abuse Rehabilitation Services (ASARS)	20% increase to state plan substance use disorder procedure codes
Federally Qualified Health Centers (FQHC)	Per-Member-Per-Month (PMPM) payment
Adult Day Health Providers (ADHP)	Allow retainer payments when they cannot operate New rate for telephonic or other remote wellness visit
Personal Care Aides (PCAs) Licensed Practical Nurses (LPNs), Registered Nurses (RNs) for home health aide Private Duty Nursing (PDN)	Enhanced rate for overtime hours worked Enhanced rate for services provided to a medically quarantined beneficiary. Enhanced rate for costs incurred in utilizing contract staff through a staffing agency to meet workforce shortage challenges.

It was anticipated that the combination of relaxed eligibility policies and the economic decline created by the response to the pandemic would generate upward pressures on enrollments for both the Medicaid and Alliance programs. In the early months of the pandemic, enrollment levels grew slowly but we are now seeing more significant increases as the pandemic lingers, as noted in the graph on page 8. While increases are witnessed for both programs, the rate of increase in Alliance enrollments since the month before the pandemic was first recognized in the District is twice the level observed for the Medicaid program. Given the historical cost pressures in the locally funded Alliance program, once the public health emergency ends, the enrollment trends and any underlying cost pressures will bear watching.

Creating Program Flexibility For Providers. During the early months of the pandemic, Americans dramatically reduced their use of preventive and elective health care. Nationwide, in March and April, for example, healthcare utilization plummeted by 23 and 52 percent, respectively. Most worrisome, diagnostic procedures, which are critical to the early detection of disease before more serious complications emerge, dropped by 65 percent. In the District,



providers across the health care delivery spectrum cited major reductions in patients visits, in some cases, threatening the viability of certain provider groups.

To address this problem, DHCF staff worked with its federal partner to greatly expand the use of telemedicine services with the goal of increasing health care utilization to near pre-pandemic levels. The key change to expanding telemedicine was the allowance made for the patient's home to be the originating site, thus eliminating the need for the patient to travel to a predesignated facility. In addition, changes were made locally and federally to allow audio-only services, permit physicians to document consent in clinical notes, and relax HIPPA requirements for non-compliant technology.

Further, in July 2020, CMS approved DHCF's request for emergency telehealth support. Based on this support, the DC Primary Care Association (DCPCA) received and distributed over

400 laptops to Medicaid providers. These laptops are configured to support provider and clinical staff access to telehealth applications and services. Each laptop is paired with a mobile hot spot that includes a one-year unlimited data service plan. Moreover, DCPCA also distributed a limited number of HIPAA-compliant telehealth platform licenses to provider organizations that would like to begin using telehealth services to enable continuity of care for their patients. Provider access to a telehealth platform license will be prepaid to cover one year of telehealth operations.

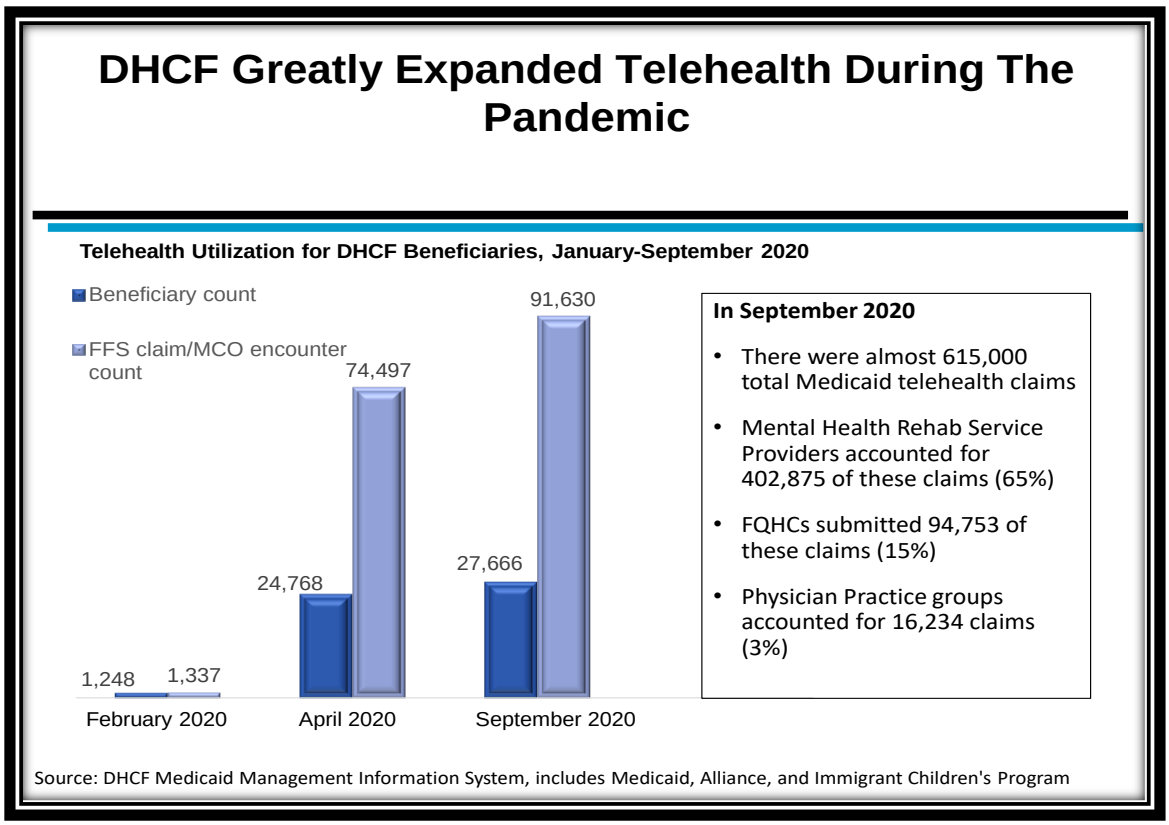
The impact of all these changes has been considerable. In January and February 2020, telehealth accounted for just 0.3 percent of outpatient claims and only 0.8 percent of beneficiaries had a telehealth service. By the months of April–September 2020, telehealth claims accounted for 21 percent of all DHCF outpatient claims and 31 percent of DHCF beneficiaries received a telehealth service.

The graph on page 10 illustrates the change in the number of beneficiaries using telehealth over this period, as well as the telehealth claim count. In the month before the pandemic, we see that less than 1,250 beneficiaries generated 1,337 telehealth claims. By September 2020, those numbers were 27,666 beneficiaries and 91,630 claims.

Major Priorities And Accomplishments

DHCF announced a five-year plan in 2019 to reform the Medicaid delivery program by focusing on: (1) value over volume, (2) better coordinated care, and (3) increased access to care. In addition to responding to the public health emergency, DHCF achieved the first major milestones to transform the Medicaid delivery system and started laying the foundation for future milestones during FY2020.

In January 2020, new Medicaid behavioral health services authorized under the Section 1115 Medicaid Behavioral Health Transformation Demonstration Waiver (Section 1115 Waiver)



became available to Medicaid beneficiaries with additional services added throughout the fiscal year. In July 2020, DHCF announced its intention to award three contracts for the District's Medicaid managed care program. Through the new contracts, DHCF stabilized the managed care program, implemented universal contracting, expanded value-based purchasing, and added enhanced care coordination requirements to ensure a greater focus on access and accountability. On October 1, 2020, over 16,000 Adults with Special Health Care Needs transitioned from the FFS Medicaid program into managed care. The transition increased access to care as these individuals became eligible for care coordination and case management services not provided in the FFS program.

Efforts towards better integrating Medicaid and Medicare services continued through the fiscal year. The request for proposals for the Program for All Inclusive Care for the Elderly (PACE) was issued in 2020. Planning for a more comprehensive District Dual Choice program, to be

implemented January 1, 2022, continued with soliciting stakeholder input through a formal Request for Information and engaging the provider community.

Behavioral Health Transformation. Both medical and behavioral health factors are important parts of a person's overall health and delivering care in an integrated fashion results in better care and health for the whole person. DHCF and the Department of Behavioral Health (DBH) proposed a three-phase approach to behavioral health transformation that will result in a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

Phase I of the District's Medicaid behavioral health transformation efforts were initiated in 2019 with DHCF and DBH's collaboration and joint development of the Section 1115 Waiver. Phases II and III center first on the integration of behavioral health services into the managed care contracts and then incentivizing integrated care through payment reform.

The waiver is intended to provide a broader continuum of behavioral health services and supports for individuals with serious mental illness, substance use disorder, and or other behavioral health needs. Ten new benefits were added over the fiscal year through the waiver program. The services that went live in January, pre-pandemic, have seen greater utilization than those services which began later in the year. For example, over 1,600 individuals utilized the available IMD services and nearly 1,000 individuals utilized recovery support services—both services were implemented in January 2020. Through the pandemic, DHCF and DBH have worked with providers to identify opportunities to safely provide these new benefits.

Now that the waiver is operational, the focus is to continue to raise awareness of the new benefits and to ensure beneficiaries have access to care. DHCF has contracted with IMPAQ International to conduct an evaluation of the District's Section 1115 Waiver as required by CMS.

The evaluation includes surveying over 1,600 beneficiaries to understand beneficiaries' experiences with the services available under the waiver and any barriers to accessing behavioral health services from their perspective. Additionally, IMPAQ will conduct key informant interviews with representatives from DHCF, DBH, DC Health, and District Medicaid MCOs, as well as community stakeholders to identify the challenges and catalysts to implementation.

DHCF also engaged in efforts throughout the fiscal year to meet the goals of Phases II and III. In August 2020, DHCF and DBH jointly issued a Request for Information (RFI), "Medicaid Behavioral Health Transformation in the District of Columbia: A Roadmap to Integrated Care", to solicit information from consumer organizations, the provider community, health plans, and others regarding the pathway to integrate behavioral services more fully into the benefits offered through the District's Medicaid managed care program. A total of 16 responses were received to the 21 questions posed in the RFI. Overall, most respondents were supportive of transforming behavioral health care in the District. Respondents provided feedback on the principles for Medicaid behavioral health reform, the definition of integrated care, and specific approaches and strategies to achieve goals of transformation. Two notable areas of feedback that require additional research, discussion, and consideration include language in the MCO contract around provider networks and a restructuring or re-assessing rates for behavioral health services.

The Medicaid Substance Use Disorder (SUD) provider capacity grant activities are laying the groundwork for Phase III. The grant activities include a comprehensive needs assessment of Medicaid provider capacity to diagnose and treat SUD, education and technical assistance among Medicaid providers to build capacity to treat individuals with SUD in community settings, and infrastructure to enable structured data collection and communication with District behavioral

health providers; as well as, the development and implementation of consent management tools to facilitate appropriate exchange of SUD patient record data.

Managed Care Program Stabilization. DHCF, through the Office of Contracts and Procurement (OCP), issued a Request for Proposal (RFP) in January 2020 with the goal to stabilize the managed care program by addressing chronic issues within program. The problems with the uneven distribution of high-cost members across the agency's three health plans was addressed by including a provision that allows DHCF to reduce funding for any MCO in amounts that ensure the medical expenditures will be at least 85 percent of total MCO revenue. Other provisions increase access to care through mandated universal contracting, increase value-based payments, and expand care coordination. The contracts for the District's Medicaid managed care program were awarded to AmeriHealth Caritas District of Columbia, Inc.; MedStar Family Choice; and CareFirst BlueCross BlueShield Community Health Plan District of Columbia (formerly known as Trusted Health Plan).

The contract implementation was the most significant transition of the managed care program in the agency's recent history. Specifically, all enrollees were randomly assigned to one of the three MCOs and the program expanded to include new enrollees previously served through the FFS program. In preparation for these changes, DHCF conducted outreach to the impacted individuals through mail, text messaging, and virtual townhalls. To ensure continuity of care, DHCF established a formal transition period from October 1 through December 31, 2020. During this time, providers were guaranteed payment regardless of their contracted status with a particular MCO. DHCF responded to beneficiary and provider issues by establishing distinct beneficiary and provider hotlines within days, manned by DHCF staff with the ability to resolved issues at the point of time, when possible.

Changes seldom occur without challenges and the MCO transition was no exception. As the agency continues reform efforts, there are lessons we will carry forward from the transition. First, utilizing multiple channels for outreach is important and this approach should be more inclusive of beneficiaries, providers, and other stakeholder groups. Second, as the program pivots to all managed care, it is imperative that DHCF better communicate baseline expectations for MCOs in ways that are accessible to stakeholders. Third, general education of both the program's benefits and the managed care delivery system is needed for both beneficiaries and providers.

Next Steps Moving Forward With Medicaid Reform

The goal of reform is to improve health outcomes so that District residents can live their best lives. Our work is guided by three strategic priorities:

1. Building a health system that provides whole person care;
2. Ensuring value and accountability; and
3. Strengthening internal operational infrastructure.

These remain unchanged since reform efforts were announced. However, a fourth priority—public health emergency response, monitoring, and closure—was added during the fiscal year to reflect the current environment. DHCF continues preparing for implementation of the PACE and District Dual Choice programs and the carve-in of behavioral health services into the managed care program. DHCF will also continue work towards changing how care is paid for – moving from paying for the volume of services to paying for value and better outcomes.

DHCF and DBH have developed a robust project structure to continue preparing for the integration of behavioral health services into managed care. This work includes the creation of a Stakeholder Advisory Group consisting of up to 30 members who are consumers (51 percent of the membership will be Medicaid beneficiaries), caregivers, consumer organizations, providers

and provider organizations, MCO, and District employees. This group will provide feedback as DHCF and DBH consider new Medicaid services, contractual considerations for the MCO contracts, performance management requirements, and provider rates.

In the managed care program, the new contract puts a greater emphasis on value-based contracting. By the end of FY2022 MCOs must have 25 percent of total medical expenditure payments to providers linked to a value-based payment strategy. In the first year of the contract FY2021, all MCOs must complete an alternative payment model assessment from which DHCF will determine the baseline amount of payment arrangements that are within Categories 2 through 4 of the multi-payer Health Care Payment Learning and Action Network (HCPLAN). DHCF will collaborate with the MCOs to evolve payment expectations and incentives.

Finally, the lens in which we move forward with Medicaid reform now considers the public health emergency. The agency's reform work will consider how we can better support resilience across the health system and how we can leverage changes undertaken during the PHE that have proven to better support District residents as they access and interact with the health care system.

Conclusions

Mr. Chairman, this concludes my performance oversight testimony on the activities of the Department of Health Care Finance over the last 16 months. As outlined, we maintained progress in reforming the Medicaid program while undertaking a number of actions in response to the public health emergency and adjusting how we do our daily work.

My staff and I look forward to working with you and the Council to ensure continuity of care during the PHE and moving forward. Thank you for this opportunity to testify and we are ready to receive your questions and those of the remaining members of the Committee on Health.